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AMEDD Coding Improvement:
Leveraging Coding Accuracy to Improve Clinical Business Management

AHIMA Joint Military Session

San Diego, CA

November 17, 2005

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Objectives

- AMEDD coding environment background
- AMEDD coding improvement program
  - Overall process redesign
  - Progress to date of selected initiatives
- The way ahead
- Conclusion

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Statement of the Problem

6b. Outcome of monthly outpatient coding audit: What is the percentage of E&M codes deemed correct?

Reporting Month	Jun-04	Jul-04	Aug-04	Sep-04	Oct-04	Nov-04	Dec-04	Jan-05	Feb-05	Mar-05	Apr-05	May-05
Data Month	Apr-04	May-04	Jun-04	Jul-04	Aug-04	Sep-04	Oct-04	Nov-04	Dec-04	Jan-05	Feb-05	Mar-05
Army	83%	83%	83%	83%	85%	81%	82%	82%	83%	83%	87%	80%
18TH MEDCOM	96%	96%	70%	74%	72%	70%	80%	70%	74%	70%	78%	78%
SEOUL	96%	96%	70%	74%	72%	70%	80%	70%	74%	70%	78%	78%
ERMC	78%	77%	84%	81%	81%	80%	82%	82%	78%	90%	87%	86%
*HEIDELBERG	74%	78%	90%	87%	86%	81%	71%	80%	83%	89%	74%	81%
*LANDSTUHL	66%	70%	65%	67%	64%	67%	82%	81%	73%	87%	94%	88%
WUERZBURG	93%											
GPRMC	90%											
*FT. BLISS	99%											
*FT. CARSON	98%											
FT. HOOD	100%											
FT. HUACHUCA	97%											
FT. LEAVENWORTH	100%											
*FT. LEONARD WOOD	67%	51%	75%	94%	9							
*FT. POLK	98%	100%	95%	99%	10							
FT. RILEY	100%	100%	100%	100%	10							
*FT. SAM HOUSTON	87%	91%	98%	98%	9							
*FT. SILL	50%	55%	78%	78%	8							
NARMC	76%	87%	89%	89%	8							
FT. BELVOIR	95%	97%	90%	95%	9							
*FT. BRAGG	69%	88%	88%	88%	7							
FT. DRUM	97%	97%	94%	95%	9							
*FT. EUSTIS	64%	68%	94%	85%	7							
FT. KNOX	30%	97%	96%	98%	9							
*FT. LEE	72%	69%	64%	61%	6							
FT. MEADE	87%	90%	87%	88%	9							
FT. MONMOUTH	100%	100%	100%	100%	10							
WALTER REED	63%	77%	89%	90%	9							
WEST POINT	82%	91%	88%	95%	10							
PRMC	89%	49%	74%	82%	8							
TAMC	77%	0%	47%	63%	7							
JAPAN	100%	97%	100%	100%	10							
SERMC	91%	88%	86%	87%	8							
*FT. BENNING	84%	92%	86%	80%	8							
*FT. CAMPBELL	81%	83%	83%	83%	7							
*FT. GORDON	90%	77%	63%	75%	5							
*FT. JACKSON	99%	99%	99%	96%	9							
*FT. RUCKER	93%	95%	95%	95%	10							
*FT. STEWART	95%	75%	81%	85%	8							
*REDSTONE ARSENAL	97%	97%	93%	96%	10							
WRMC	59%	52%	58%	84%	4							
FT. IRWIN	92%	91%	92%	92%	9							
FT. LEWIS	27%	40%	28%	66%	5							
*FT. WAINWRIGHT	57%	26%	55%	94%	6							

entage of ICD-9

										Mar-05	Apr-05	May-05
										Jan-05	Feb-05	Mar-05
Army	81%	81%	81%	81%	83%	79%	84%	84%	82%	85%	85%	84%
18TH MEDCOM	96%	96%	72%	62%	70%	68%	78%	68%	70%	72%	78%	70%
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*LANDSTUHL	87%	89%	79%	82%	68%	78%	87%	84%	78%	90%	97%	98%
WUERZBURG	71%	75%	88%	80%	81%	81%	95%	78%	89%	92%	88%	94%
GPRMC	92%	84%	92%	95%	96%	87%	87%	95%	89%	90%	90%	92%
*FT. BLISS	96%	98%	98%	98%	98%	98%	97%	100%	97%	97%	100%	96%
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FT. HOOD	98%	99%	99%	82%	93%	61%	80%	97%	99%	82%	65%	86%
FT. HUACHUCA	95%	95%	95%	96%	95%	97%	95%	94%	92%	90%	93%	94%
FT. LEAVENWORTH	98%	94%	100%	100%	95%	80%	94%	100%	85%	95%	100%	98%
*FT. LEONARD WOOD	72%	5%	61%	100%	99%	67%	50%	98%	42%	80%	97%	89%
*FT. POLK	97%	95%	97%	99%	97%	97%	100%	100%	100%	96%	90%	97%
FT. RILEY	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
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FT. DRUM	86%	97%	93%	90%	88%	93%	89%	90%	90%	90%	88%	85%
*FT. EUSTIS	63%	80%	91%	67%	88%	76%	60%	89%	63%	90%	85%	99%
FT. KNOX	49%	97%	97%	95%	97%	96%	97%	97%	98%	98%	85%	97%
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PRMC	76%	52%	83%	82%	64%	91%	72%	64%	64%	67%	74%	75%
TAMC	53%	7%	73%	63%	33%	87%	57%	33%	37%	37%	47%	50%
JAPAN	99%	97%	92%	100%	95%	94%	87%	94%	90%	97%	100%	100%
										87%	84%	82%
										82%	84%	73%
										85%	79%	89%
										75%	57%	58%
										98%	99%	92%
										97%	98%	98%
										80%	77%	75%
										92%	96%	91%
										68%	64%	57%
										80%	78%	56%
										91%	80%	69%
										33%	33%	47%

Too Much Variation!

Special Cause or
Common Cause Variation?

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Coding Compliance: Why Bother?

- Lack of standard coding / coding audit practices
  - Inability to find best practices
  - Inter and intra-rater reliability issues prevent comparability
- Direct and indirect financial consequences
  - Wasted effort – “just get it done” vs. systemic organizational improvement
  - RVU approach for future DHP budgeting
  - Future MTF staffing based on workload

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The MHS is a Business!

- Old days: “self-contained” organization
- Today, we do business with:
  - Private health care industry
  - Medicare
  - Veteran’s Administration
- NOW TMA is also a payor
- Every encounter is a *Claim*!

Elisabeth Kubler-Ross' 5 Stages of Medical Coding Improvement

- Denial Coding Is not *my* problem.
- Anger I don't know why you are making me do this!
- Bargaining How about if we just fix the "easy" ones?
- Depression I'll never understand this coding stuff!
- Acceptance We have a coding problem, and I have to help fix it

- Not Really…But It Fits!

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The Elephant in the Room

CHCS II is here to sta

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Experience Tells Us Core Competencies Required for AMEDD Coding Success Are:

1. Provider understanding of documentation, coding and reimbursement relationship
2. Complete and accurate encounter documentation
3. Fast, accurate, and inexpensive coding of encounters
4. Coding audit process that emphasizes consistency, accuracy and continuous improvement
5. Mandatory continuing education training for select coding staff
6. Positive, focused, and relevant feedback to providers regarding documentation and coding performance

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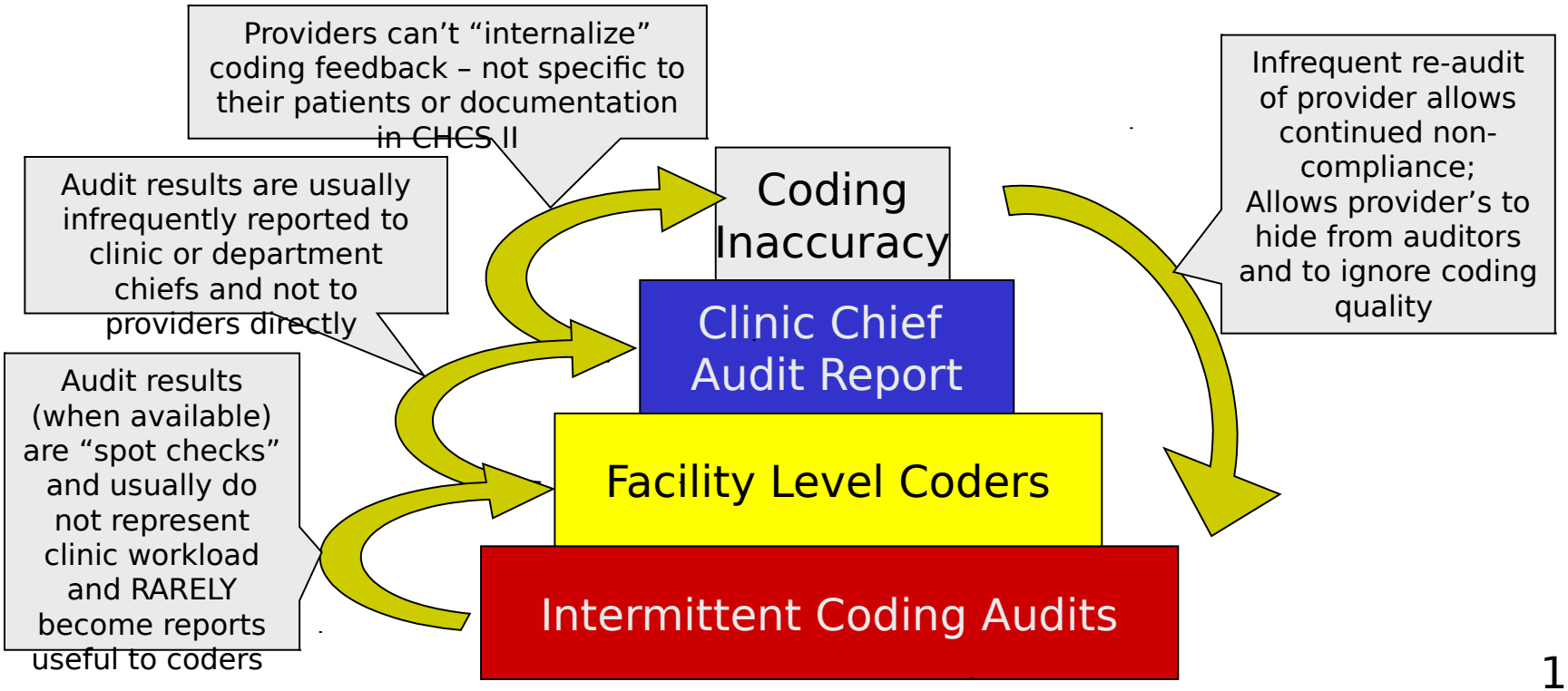
Facts Bearing on the Problem

- The AMEDD has shown poor medical coding compliance over the past several years (lack of effective program)
- Each AMEDD MTF is allowed to create and manage their own DQ audit program
- There is no centralized coordination of MTF DQ audits
- There is tremendous variation in the measurement and performance criteria of AMEDD DQ audits
- Current audit methods do not allow detailed statistical evaluation of coding performance
- Current audit methods do not allow comparability of AMEDD MTFs
- Current audit methods do not tangibly impact coding

Current AMEDD Coding Compliance Cycle

Because MTFs only “spot check” a few records from only a few providers in the facility, MTF audit data is not useful to affect systemic coding behavior change.


Providers can’t “internalize” coding feedback – not specific to their patients or documentation in CHCS II
Audit results are usually infrequently reported to clinic or department chiefs and not to providers directly
Audit results (when available) are “spot checks” and usually do not represent clinic workload and RARELY become reports useful to coders
Coding Inaccuracy
Clinic Chief Audit Report
Facility Level Coders
Intermittent Coding Audits
Infrequent re-audit of provider allows continued non-compliance; Allows provider’s to hide from auditors and to ignore coding quality

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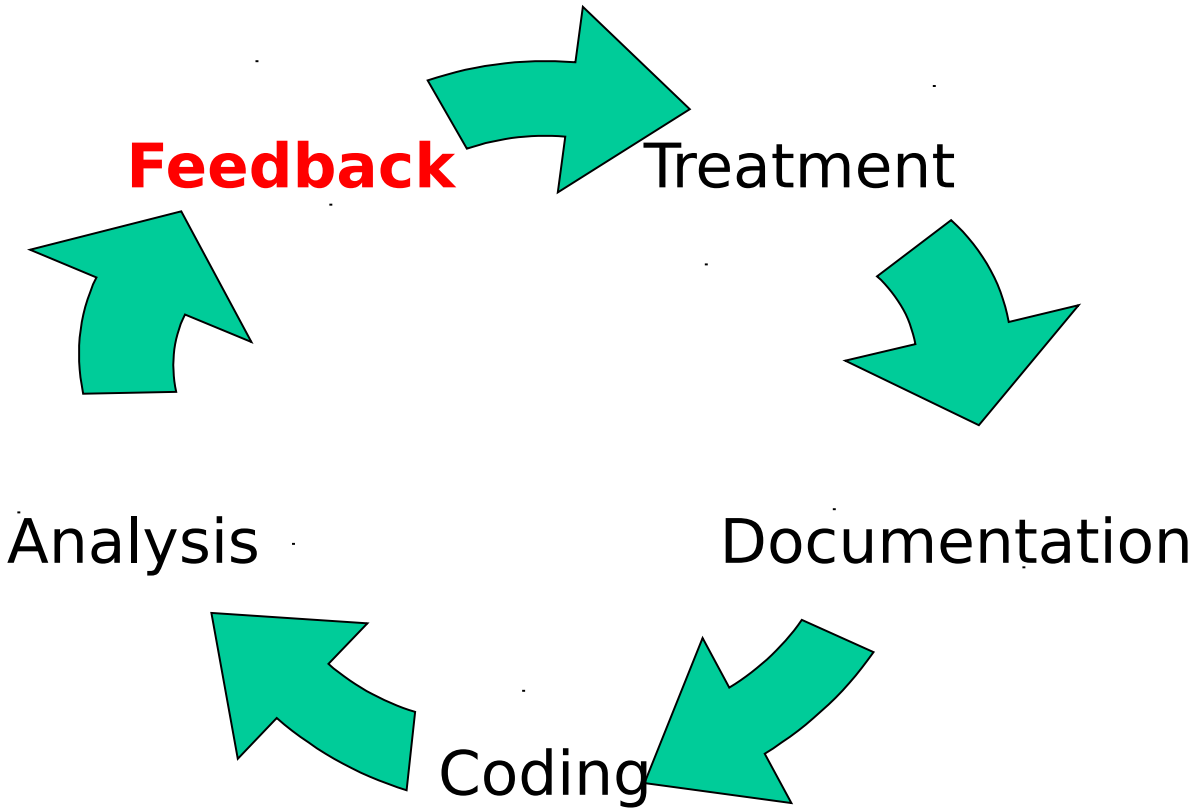
AMEDD Coding Cycle



DMAIC:
Processes within processes

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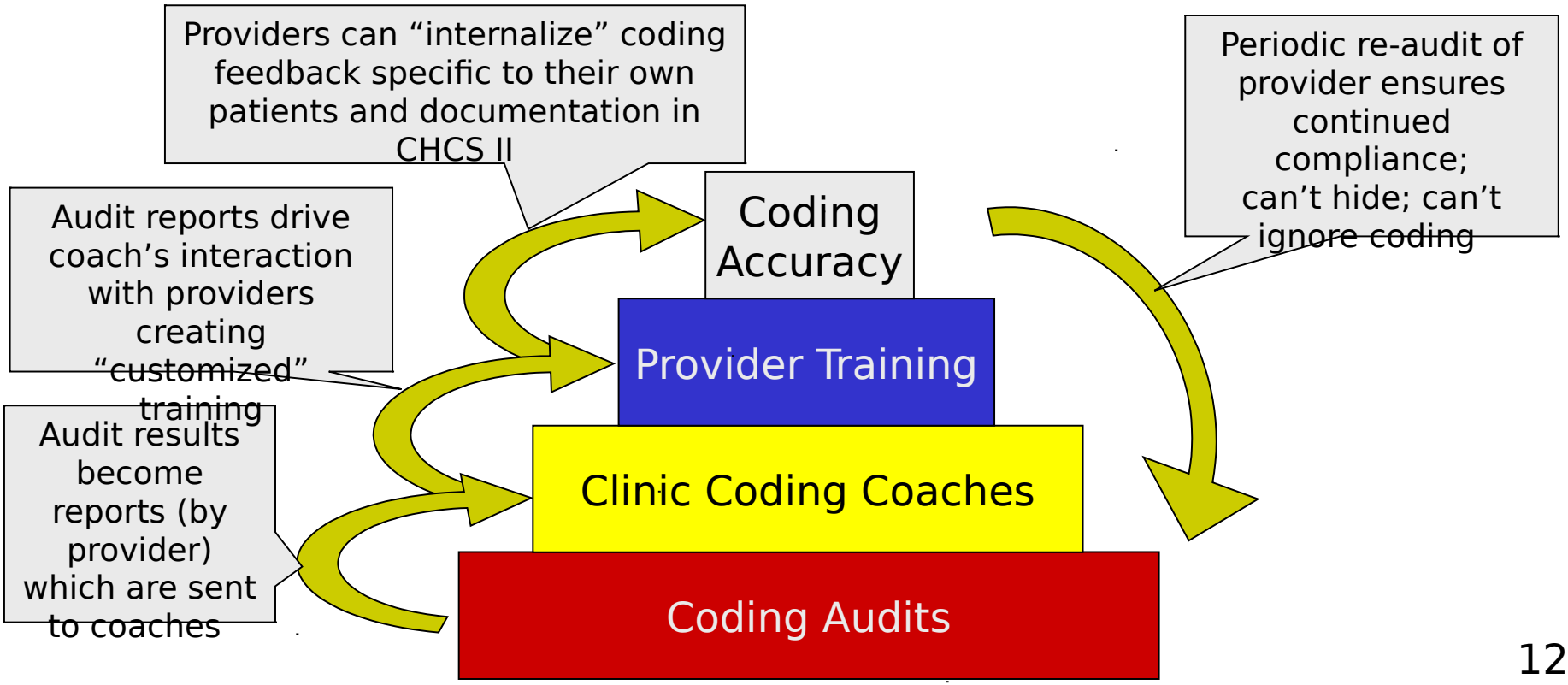
Proposed AMEDD Coding Compliance Cycle

Centralized audit reviews 100% of every AMEDD MTF's encounters for one Clinic Day per month (100% of daily MTF Workload each 30 days) creating actionable data to support organizational change


Providers can "internalize" coding feedback specific to their own patients and documentation in CHCS II
Periodic re-audit of provider ensures continued compliance; can't hide; can't ignore coding
Audit reports drive coach's interaction with providers creating "customized" training
Coding Accuracy
Provider Training
Audit results become reports (by provider) which are sent to coaches
Clinic Coding Coaches
Coding Audits

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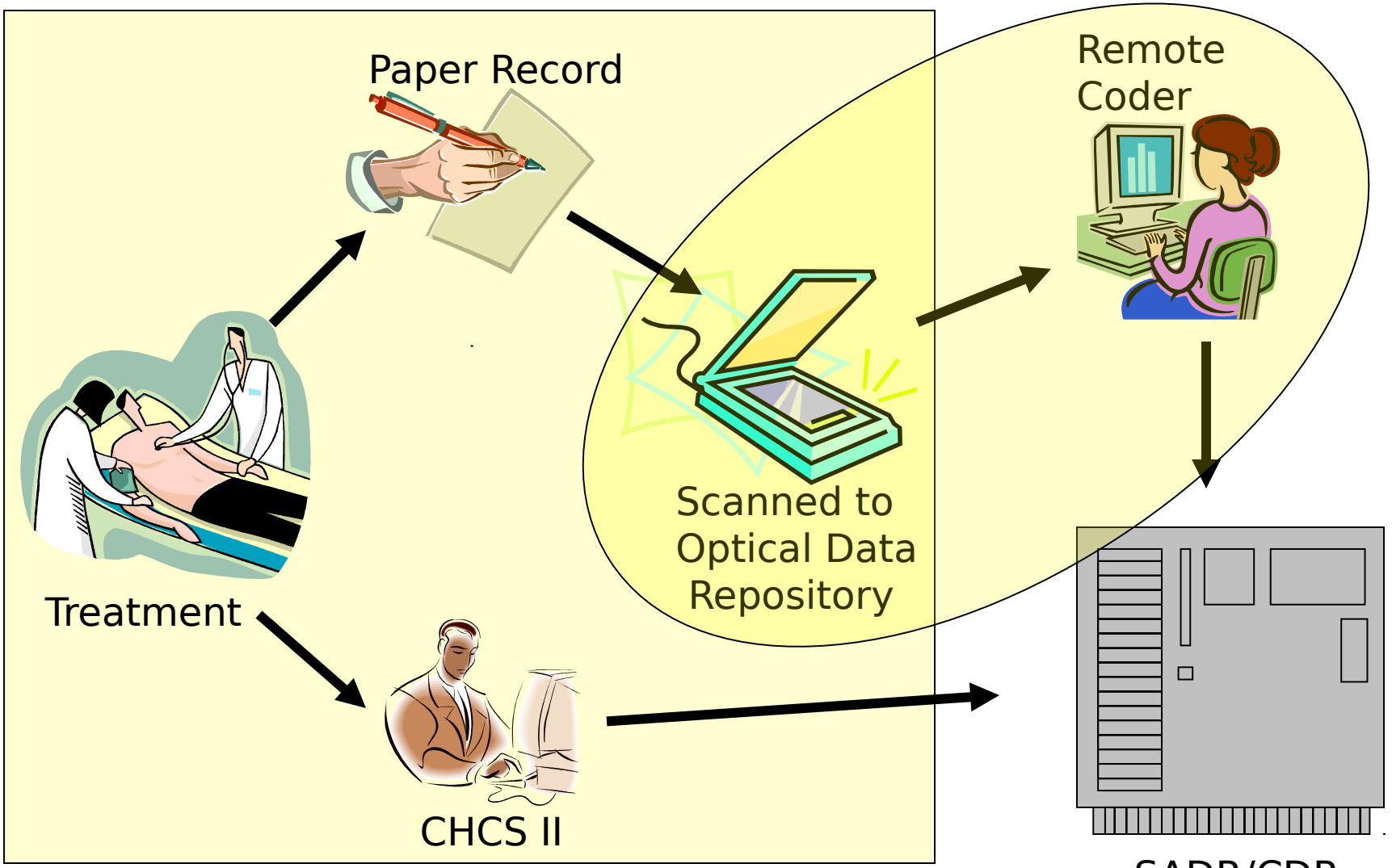
Coding Process Vision: Front End



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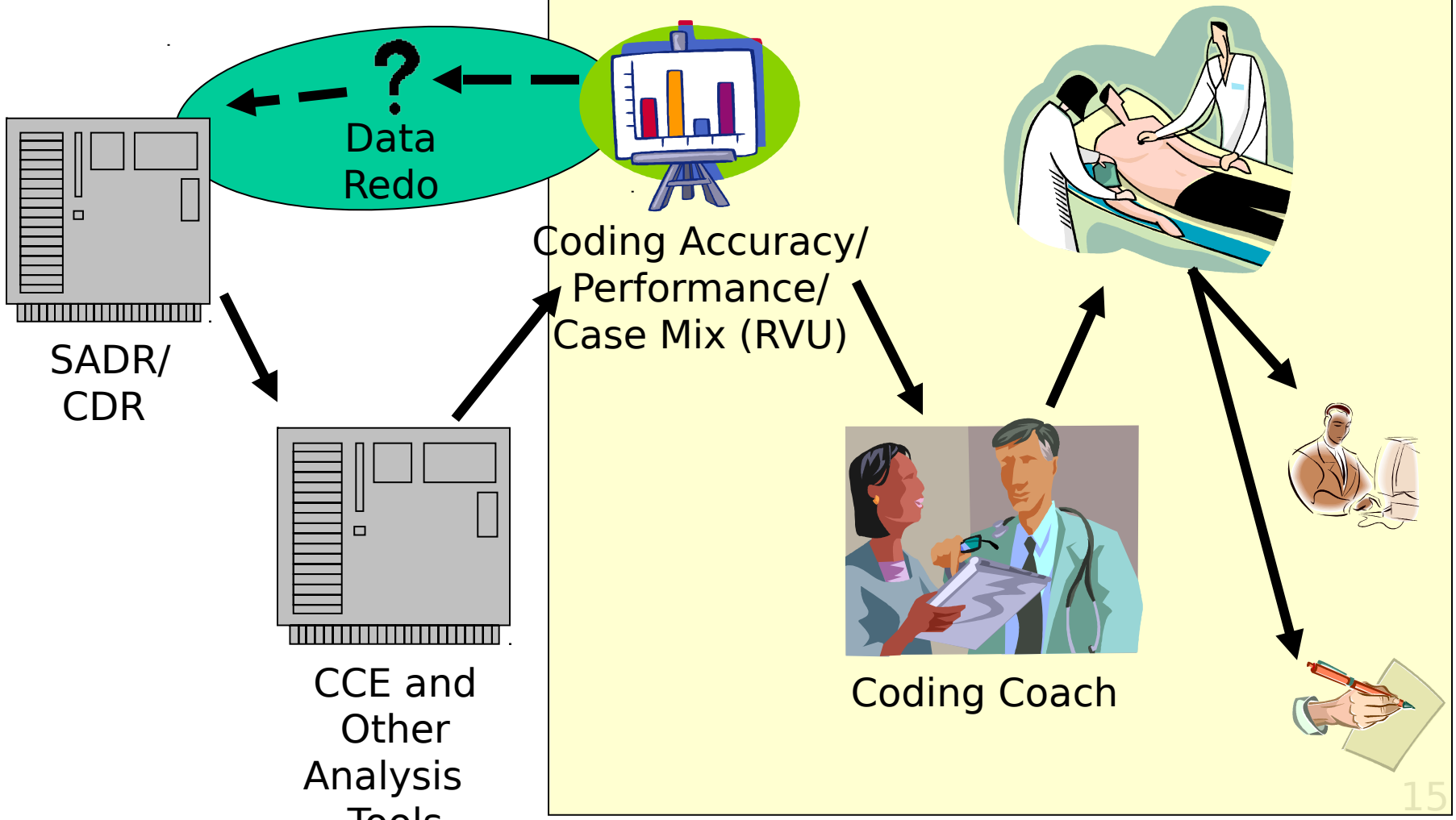
Remote Coding

BLUF: If you are looking for coding "production" RC is most economical

- AMEDD central contract for Outpatient coding
- MTFs "pay as they go"
- Migration strategy for CHCSII (short term solution)
- ROI "Bang for the Buck" far exceeds either GS or Contract in house coders

Coding Process Vision: Back End



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Coding Coaches

- Coder new role - clinic documentation “coach”
  - CHCS II is here to stay
    - Provider documents and software codes
  - Coder co-located with clinical service
  - Creates “business tension” with providers
  - MTF clinical business change agent – “Drives” the Revenue Cycle

- Four critical skill components
  - Coding certification = credibility
  - Compliance audit skills = reports interpretation
  - Training/facilitation skills = interpersonal
  - Clinical business management understanding
    - Requires in-depth understanding of impact of coding on revenue
    - Currently lacking in most MTFs

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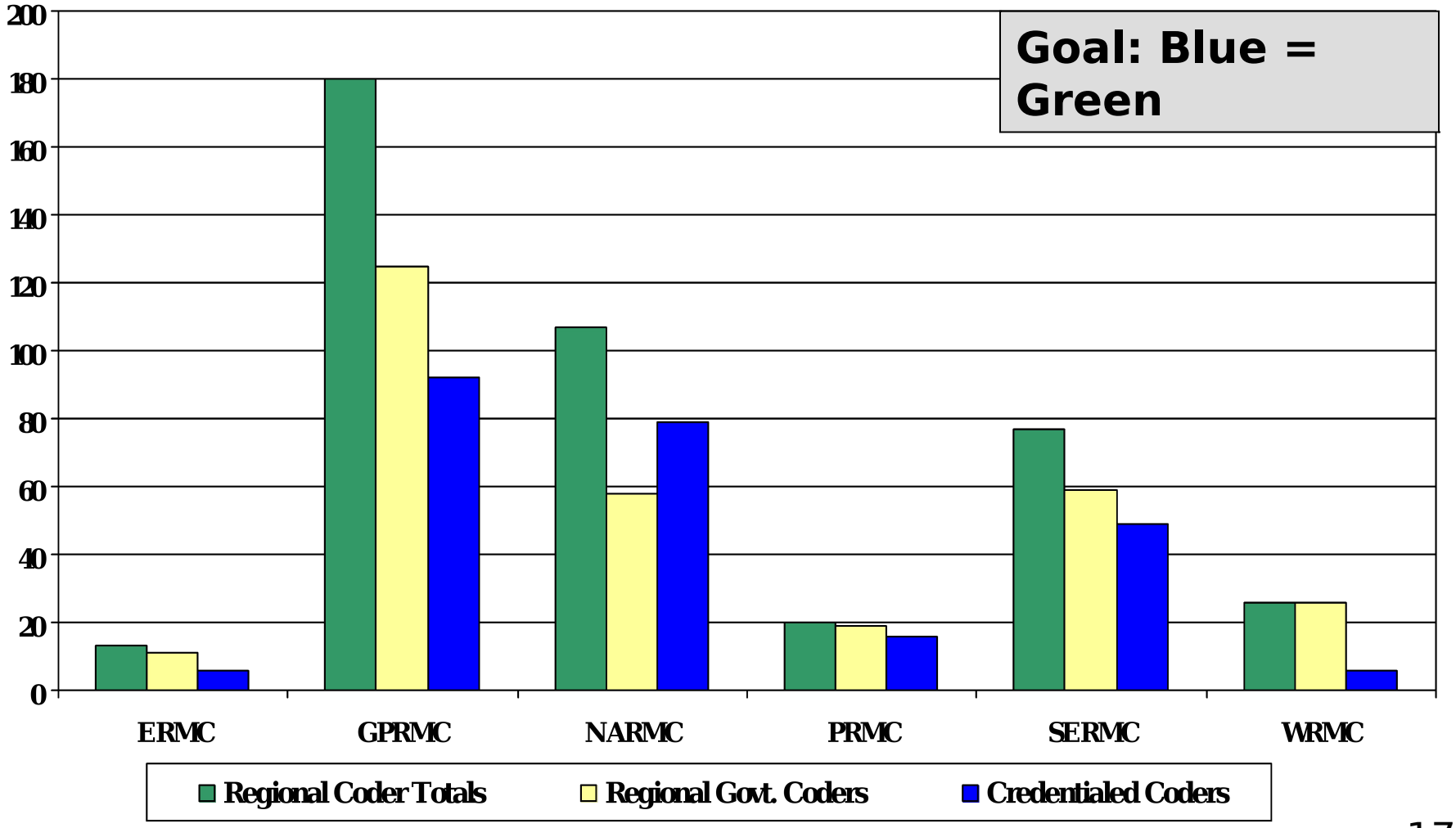
Coding Training (Credentialed Coders)



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Coding Audit Program Revision

- Currently MTF staff performs audits with limited central direction or oversight.
- Issues associated with lack of central direction include:

"Herding Cats" Mentality
Self Reported Data
"Just Get it Done" vs. Learning Organization

WE CAN'T FIX THE CODING PROBLEMS IF WE DON'T KNOW WHAT THE PROBLEMS ARE

- Centralized Coding Audit Authority (PASBA)
  - **Independent auditor**
  - **Audit of one full MTF workday per month for <u>every</u> MTF**
    - **All Providers**
    - **All Encounters**

Too Much Audit Process Variance!

6b. Outcome of monthly outpatient coding audit: What is the percentage of E&M codes deemed correct?

Reporting Month	Nov-03	Dec-03	Jan-04	Feb-04	Mar-04	Apr-04	May-04	Jun-04	Jul-04	Aug-04	Sep-04	Oct-04	Next Month Nov-04
Data Month	Sep-03	Oct-03	Nov-03	Dec-03	Jan-04	Feb-04	Mar-04	Apr-04	May-04	Jun-04	Jul-04	Aug-04	Sep-04
Army	85%	82%	85%	82%	84%	83%	85%	83%	83%	83%	83%	85%	
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LANDSTUHL	56%	80%	83%	77%	75%	69%	72%	66%	70%	65%	67%	64%	
WUERZBURG	84%	84%	80%	85%	84%	89%	85%	93%	84%	96%	89%	94%	
GPRMC	95%	92%	90%	78%	87%	86%	92%	90%	84%	91%	94%	96%	
FT. BLISS	91%	95%	95%	95%	95%	96%	96%	99%	97%	97%	95%	99%	
FT. CARSON	100%	96%	96%	88%	91%	95%	97%	98%	74%	94%	99%	95%	
FT. HOOD	95%	83%	82%	64%	82%	90%	91%	100%	78%	77%	84%	88%	
FT. HUACHUCA	97%	82%	97%	86%	97%	98%	95%	97%	95%	98%	96%	95%	
FT. LEAVENWORTH	98%	98%	100%	100%	96%	100%	96%	100%	100%	100%	100%	100%	
FT. LEONARD WOOD	99%	82%	90%	14%	33%	26%	98%	67%	51%	75%	94%	96%	
FT. POLK	100%	100%	100%	100%	95%	100%	83%	98%	100%	95%	99%	100%	
FT. RILEY	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
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FT. EUSTIS	43%	41%	93%	70%	86%	49%	57%	64%	68%	94%	85%	71%	
FT. KNOX	96%	96%	97%	97%	98%	91%	93%	30%	97%	96%	98%	98%	
FT. LEE	64%	49%	71%	71%	70%	68%	69%	72%	69%	64%	61%	68%	
FT. MEADE	76%	89%	85%	93%	92%	95%	95%	87%	90%	87%	88%	92%	
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PRMC	74%	58%	65%	84%	95%	78%	89%	89%	49%	74%	82%	89%	
TAMC	47%	17%	33%	67%	90%	55%	77%	77%	0%	47%	63%	77%	
JAPAN	100%	100%	97%	100%	100%	100%	100%	100%	97%	100%	100%	100%	
SERMC	80%	83%	91%	92%	89%	92%	90%	91%	88%	86%	87%	84%	
FT. BENNING	70%	96%	87%	88%	78%	88%	92%	84%	92%	86%	80%	81%	
FT. CAMPBELL	27%	67%	92%	86%	75%	81%	73%	81%	83%	83%	83%	70%	
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WRMC	82%	76%	53%	58%	70%	61%	54%	59%	52%	58%	84%	49%	
FT. IRWIN	81%	75%	86%	90%	75%	89%	91%	92%	91%	92%	92%	91%	
FT. LEWIS	100%	88%	41%	52%	100%	78%	45%	27%	40%	28%	66%	56%	
FT. WAINWRIGHT	66%	66%	33%	33%	36%	17%	27%	57%	26%	55%	94%	0%	

Legend: 95% - 100% | 80% - 94% | Below 80%

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The Way Ahead:

It ain’t business as usual folks!

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FY06 Proposed Coding Improvement Program: Improving Clinical Business

- Primary Care
  - E&M Coding
    - Drive MD provider use of 99211 to zero
    - Convert % of 99211 Nurse/Tech visits to higher RVU MD visits
    - Maximize “New Patient” opportunities
  - T-Con Usage
    - Convert Nurse/Tech T-Cons to MD T-Cons
    - Change T-Con code mix % to bell curve
- Specialty Care
  - Use Consult vs. Referral or New Patient
- Allied Health
  - Tech visits conducted as “Incident to” service of PT,OT

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Future of Coding Improvement

- First code correctly – then optimize clinical business
- We are starting from zero – measurable improvement will take time

- Optimization Expectations (2 years)
  - .5 RVU average per encounter increase in Primary Care (30-40% of total AMEDD workload)
  - Loss of .5 average RVU per encounter in Allied Health specialties (20% of AMEDD workload) **but** increased workload
  - At least 1 full average RVU per encounter increase in surgical specialties (20% of AMEDD workload)

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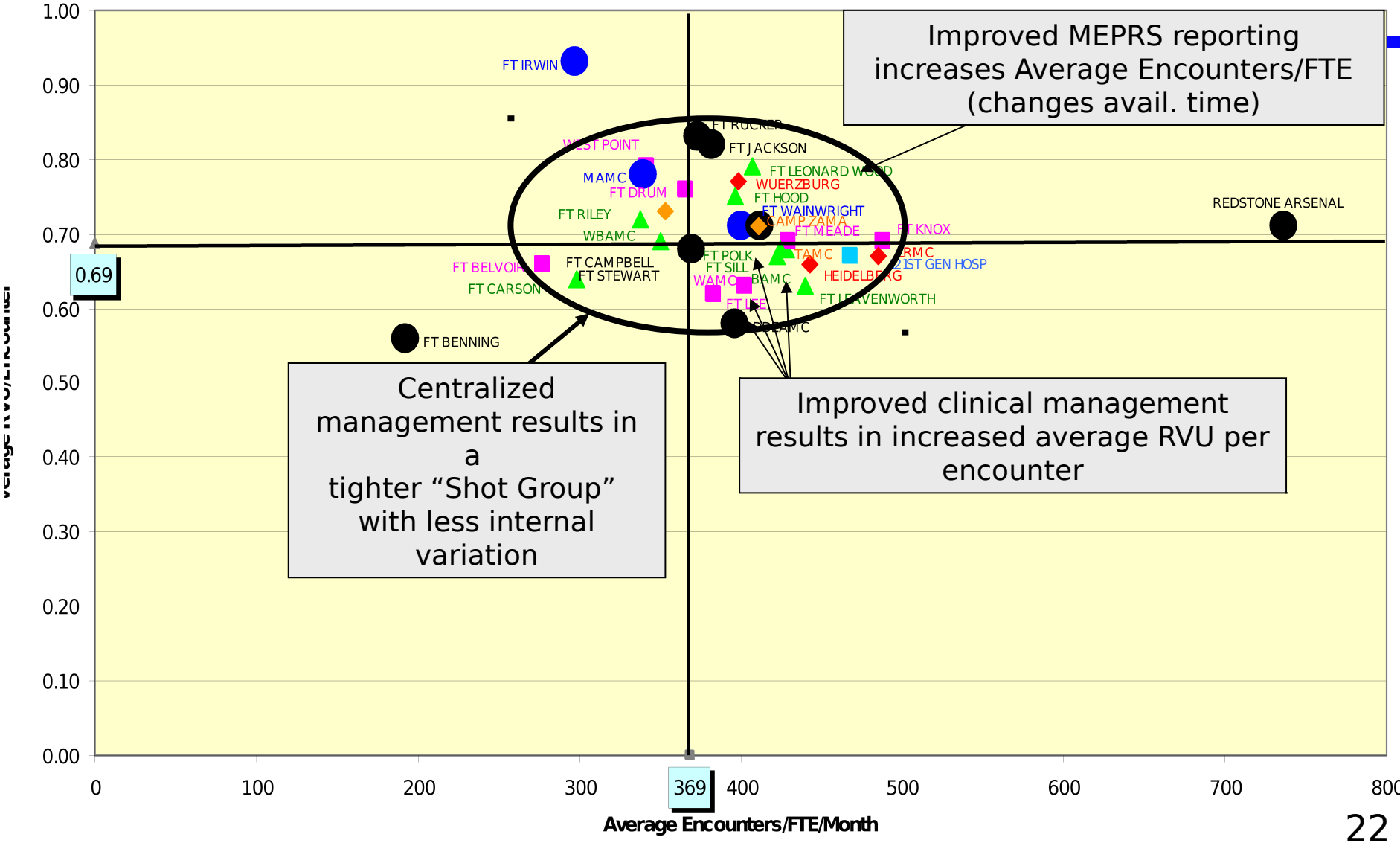
Family Practice April 05



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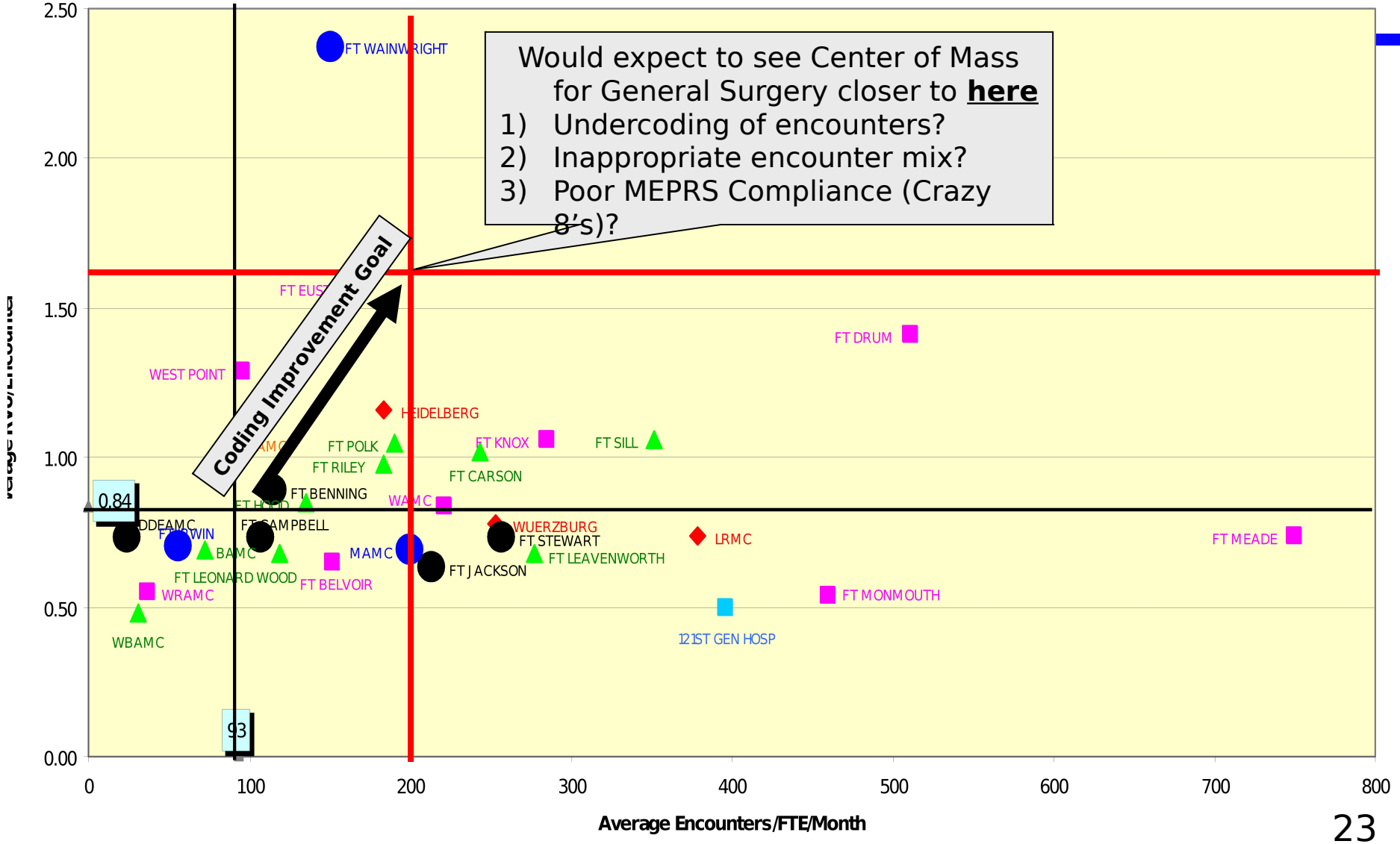
General Surgery April 05



PASBA
THE AMEDD LINK TO QUALITY
INFORMATION FOR EFFECTIVE MANAGEMENT

Conclusion

Thank you!

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